

the blood or red cells is deemed to have been replaced.

(c) *Provider's right to charge for the first 3 units of whole blood or packed red cells*—(1) *Basic rule.* Except as specified in paragraph (c)(2) of this section, a provider may charge a beneficiary its customary charge for any of the first 3 units of whole blood or packed red cells.

(2) *Exception.* A provider may not charge the beneficiary for the first 3 units of whole blood or packed red cells in any of the following circumstances:

(i) The blood or packed red cells has been replaced.

(ii) The provider (or its blood supplier) receives, from an individual or a blood bank, a replacement offer that meets the criteria specified in paragraph (d) of this section. The provider is precluded from charging even if it or its blood supplier rejects the replacement offer.

(iii) The provider obtained the blood or packed red cells at no charge other than a processing or service charge and it is therefore deemed to have been replaced.

(d) *Criteria for replacement of blood.* A blood replacement offer made by a beneficiary, or an individual or a blood bank on behalf of a beneficiary, discharges the beneficiary's obligation to pay for deductible blood or packed red cells if the replacement blood meets the applicable criteria specified in Food and Drug Administration regulations under 21 CFR part 640, i.e.—

(1) The replacement blood would not endanger the health of a recipient; and

(2) The prospective donor's health would not be endangered by making a blood donation.

[48 FR 12541, Mar. 25, 1983, as amended at 56 FR 8840, Mar. 1, 1991; 57 FR 36014, Aug. 12, 1992; 58 FR 30666, 30667, May 26, 1993]

§ 409.89 Exemption of kidney donors from deductible and coinsurance requirements.

The deductible and coinsurance requirements set forth in this subpart do not apply to any services furnished to an individual in connection with the

donation of a kidney for transplant surgery.

Subpart H—Payment of Hospital Insurance Benefits

SOURCE: 53 FR 6633, Mar. 2, 1988, unless otherwise noted.

§ 409.100 To whom payment is made.

(a) *Basic rule.* Except as provided in paragraph (b) of this section—

(1) Medicare pays hospital insurance benefits only to a participating provider.

(2) For home health services (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who at the time the item or service is furnished is under a plan of care of an HHA, payment is made to the HHA (without regard to whether the item or service is furnished by the HHA directly, under arrangement with the HHA, or under any other contracting or consulting arrangement).

(b) *Exceptions.* Medicare may pay hospital insurance benefits as follows:

(1) For emergency services furnished by a nonparticipating hospital, to the hospital or to the beneficiary, under the conditions prescribed in subpart G of part 424 of this chapter.

(2) For services furnished by a Canadian or Mexican hospital, to the hospital or to the beneficiary, under the conditions prescribed in subpart H of part 424 of this chapter.

[53 FR 6633, Mar. 2, 1988, as amended at 65 FR 41211, July 3, 2000]

§ 409.102 Amounts of payment.

(a) The amounts Medicare pays for hospital insurance benefits are generally determined in accordance with part 412 or part 413 of this chapter.

(b) Except as provided in §§ 409.61(d) and 409.89, hospital insurance benefits are subject to the deductible and coinsurance requirements set forth in subpart G of this part.